



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SIERRA MEDICAL CENTER
PO BOX 809053
DALLAS TX 75380

Respondent Name

CITY OF EL PASO

Carrier's Austin Representative Box

Box Number: 19

MFDR Tracking Number

M4-04-2412-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Carrier reimbursed some items at fee guideline, some at 50%, some not at all. Carrier inappropriately requested implant invoices. Please review TWCC rule 134.401, Section (c) Reimbursement, (4) Additional Reimbursements (specifically implantables, rev codes 276 and 278) that are paid at cost plus 10% apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section. Please review Section c (6)(A)(iii, iv, v). It states that if audited charges exceed these stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor of 75%. Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are 1.) personal items; 2.) If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted and items and; 3.) services not related to the injury may be deducted. Carrier did not perform on on-site audit, there are no charges unrelated to the injury. There were no personal items. An appeal was faxed to the carrier on 9/15/03. I've enclosed that fax confirmation in this packet. The appeal was sent three weeks ago, but I needed to submit the MDR now, to guarantee it's timeliness."

Amount in Dispute: \$28,798.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After careful review of the hospital bill our position remains the same. The provider billed a total of \$51,944.40 for date of service 10-16-02 thru 10-17-02 and is requesting total reimbursement of \$38,958.30 (75% of the billed amount), based on the stop-loss reimbursement methodology. We reimbursed a total of \$10,159.40 using our methodology that was based on rule 134.401: (6)(A) *Explanation: (i) To be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold. (ii) This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.* The bill was reviewed by our Physician Advisor and it was determined this procedure was not considered '**unusually extensive**'; therefore, we recommended payment based on rule 134.401 Acute Care Inpatient Hospital Fee Guidelines, per diem methodology. In addition to rule 134.401 the Texas Labor Code 413.011(d) states: 'Guidelines for medical service fees must be fair and reasonable designed to ensure the quality of medical care and to achieve effective medical cost control.' Based

on the rules quoted above, we feel our original recommended payment amount of \$10,159.40 falls within the scope of the TWCC Medical Fee Guidelines; therefore, no further payment is due.”

Response Submitted by: Ward North American, Inc. 4141 Pinnacle St., Ste. 208, El Paso, TX 79902

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2002	Outpatient Hospital Services	\$28,798.90	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on October 17, 2003. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, the Division notified the requestor on October 23, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - H – Half Payment
 - F – No according to Treatment Guidelines
 - N – Not appropriately documented.
 - 270 – No allowance has been recommended for this procedure/service/supply. Please see special “Note” below.
 - The Provider is disputing the original review stating the charges meet the criteria for stop loss method. The stop loss method applies to inpt bill charges exceeding \$40,000.00 not outpt charges exceeding \$40,000.00. Based on this information, no additional is recommended.

Findings

1. The carrier denied disputed services with denial code N - "Not appropriately documented." Review of the submitted documentation finds that the requestor submitted a copy of the operative report that documents the bone graft. Therefore, the carrier's denial code is not supported and the disputed date of service will be reviewed in accordance with the Act and Division rules.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including “a copy of any pertinent medical records.” Review of the documentation submitted by the requestor finds that the requestor provided the operative report but did not submit the anesthesia record or post-operative report or other pertinent medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of

§133.307(g)(3)(B).

5. 28 Texas Administrative Code §133.307(g)(3)(C)(i), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “a description of the healthcare for which payment is in dispute.” Review of the submitted documentation finds that the requestor did not provide a description of the healthcare for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(i).
6. 28 Texas Administrative Code §133.307(g)(3)(C)(ii), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “the requestor’s reasoning for why the disputed fees should be paid.” Review of the submitted documentation finds no documentation of the requestor’s reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(ii).
7. 28 Texas Administrative Code §133.307(g)(3)(C)(iii), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the Texas Labor Code and commission [now the Division] rules, and fee guidelines, impact the disputed fee issues.” Review of the submitted documentation finds that the requestor did not state how the Texas Labor Code and Division rules impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iii).
8. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
9. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 2, 2002, 26 *Texas Register* 10934, applicable to disputes filed on or after January 1, 2002, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that “TWCC rule 134.401, Section (c) Reimbursement, (4) Additional Reimbursements (specifically implantables, rev codes 276 and 278) that are paid at cost plus 10% apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section. Please review Section c (6)(A)(iii, iv, v). It states that if audited charges exceed these stop-loss threshold, reimbursement for the entire admission shall be paid using a Stop-Loss Reimbursement Factor of 75%. Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are 1.) personal items; 2.) If an on-site audit is performed, charges for services which are not documented as rendered during the admission may be deducted and items and; 3.) services not related to the injury may be deducted. Carrier did not perform on on-site audit, there are no charges unrelated to the injury.”
 - 28 Texas Administrative Code §134.401 is the rule that governs acute care inpatient hospital services. The requestor billed outpatient services as reflected in the UB-92. According to 28 Texas Administrative Code §134.1(c) states that reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission. The requestor did not submit documentation to support that the billed charges were inpatient charges that are subject to the rule governing inpatient hospital services.
 - The requestor does not discuss or explain how the Acute Care Inpatient Hospital Fee Guideline supports the requestor’s position that the amount sought is a fair and reasonable reimbursement for the outpatient services in this dispute.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.
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The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	February 22, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	February 22, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.